

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-028220

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3921

FILED AUG 6 1963

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Dekalb	
b. CITY (If outside corporate limits, give TOWNSHIP only) Kansas City		c. CITY OR TOWN Maysville	
Length of stay in 1b 3 days		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Saint Joseph's Hospital		d. STREET ADDRESS (If outside, give location) 15	
		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First NELSON Middle LEE Last CLOUSE			4. DATE OF DEATH Month 7 Day 11 Year 1963		
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12-30-18	9. AGE (last birthday) 44	IF UNDER 1 YEAR Months 7 Days 11 Hours 11 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (City and state or country) Stewartsville, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Edward Clouse		13b. MOTHER'S MAIDEN NAME Lucy Flubart		14. NAME OF HUSBAND OR WIFE Doris Clouse	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W W 2			16. SOCIAL SECURITY NO. Mr. Oaris Clouse: Maysville, Missouri		

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory paralysis		INTERVAL BETWEEN ONSET AND DEATH 10 min
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebral edema		3 days
DUE TO (c) Cerebral infarction		3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (not related to the terminal disease condition given in PART I (a))		
PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour 11:45 a.m. p.m.	Month, Day, Year 7-11-63		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE

21. I attended the deceased from 11:45 p.m. to 7-11-63 and last saw him alive on 7-11-63 . Death occurred at 11:45 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE [Signature] (Degree or title)		22b. ADDRESS 411 North R. R. 10th	22c. DATE SIGNED 7/12/63
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 7-12-63	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery Saint Joseph, Missouri	23d. LOCATION (City, town, or county) (State)		
24. FUNERAL DIRECTOR SUMMERFIELD FUNERAL HOME, Missouri		25. DATE RECD. BY LOCAL REG. 7-12-63	26. REGISTRAR'S SIGNATURE [Signature]		

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

961 9 AUG

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed Jack T. Moore

Licensed Embalmer No. 4729

P. O. Address Trimble, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.